AGING AND DISABILITY SERVICES ADMINISTRATION
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
NURSING ASSISTANT TRAINING PROGRAM
PO BOX 45600
OLYMPIA WA 98504-5600

DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION
PO BOX 47864
OLYMPIA WA 98504-7864

APPLICATION FOR NURSING ASSISTANT TRAINING PROGRAM APPROVAL (NATCEP)

DATE OF APPLICATION

LEGAL NAME OF SPONSORING HEALTH CARE FACILITY, HOSPITAL, SCHOOL OR OTHER ENTITY	TELEPHONE NUMBER (INCLUDE AREA CODE) ( )

MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE

STREET ADDRESS IF DIFFERENT FROM MAILING ADDRESS	CITY	STATE	ZIP CODE	E-MAIL ADDRESS

NAME OF FACILITY ADMINISTRATOR, VOCATIONAL DIRECTOR, DEPARTMENT HEAD, OR CHIEF ADMINISTRATIVE OFFICER

NAME OF PROGRAM DIRECTOR, NURSING ASSISTANT TRAINING PROGRAM	CONTACT TELEPHONE NUMBER (INCLUDE AREA CODE ( )

If facility was approved for Nursing Assistant Training previously, what is your training program approval number?

Describe the classroom space allotted to your training program. Specify type of room, square footage, self-contained or shared space, room equipment and classroom furniture, square footage, maximum number of students that can be comfortably accommodated, other uses of this room during non-class time and the availability/location of teaching materials and audio-visual equipment. Attach a separate sheet if necessary. Is this classroom off-site, that is, located elsewhere from the street address listed above? ☐ Yes ☐ No

Describe the training laboratory and the personal care equipment used for the practice of clinical skills. Attach a separate sheet if necessary.

Will the student go off-site for any clinical training? ☐ Yes ☐ No If yes, list the name(s) of these clinical training sites.

List the teaching resources for the program. For example, name and publication date of textbooks and audio-visual equipment.

Textbooks:

Audio-visuals:

Other (specify):

Number of hours proposed for your Nursing Assistant Training Program: Classroom _____ Clinical _____ Total Hours: _____

Important: Please read Page 2 of this form.

APPLICATION FOR NURSING ASSISTANT TRAININAG PROGRAM APPROVAL, Page 2

The following attachments are required for all programs. ATTACH THE FOLLOWING TO THIS APPLICATION.

- ☐ 1. Application for Nursing Assistant Program Director (NATCEP), DSHS 14-370
- ☐ 2. **Instructional Staff Applications, DSHS 14-369.** This is not applicable if the program director is the sole instructor.
- ☐ 3. A list of **course objectives** for your training program.
- ☐ 4. The **curriculum outline and schedule of class and clinical presentations**. The applicant must provide evidence of content that will lead to the achievement of all required nursing assistant competencies listed in Washington Administrative Code (WAC) 246-841 and 42CFR 483-152.
- ☐ 5 A **sample lesson plan** for one core unit of the curriculum outline. This includes a lesson plan objective and any supporting sub-objectives.
- ☐ 6. The **skills checklist** used in your program for skills achievement verification.
- ☐ 7. A **description of the evaluation methods** and your program requirements for passing. Describe below or use a separate sheet.
- ☐ 8. Copies of the required affiliated agreement with facilities where clinical training is conducted. (Non-facility based programs only)
- ☐ 9. Sample of student record form to be used by training program. If program is not in a long term care facility, attach all agreements for clinical training.